DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445294	A. BUILDING _____ B. WING _____	12/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COLLEGEDALE	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #'s 26262, 26662, 26826, were completed at Life Care Center of Collegedale on December 6-8, 2010. No deficiencies were cited related to complaint investigaion #'s 26662 and 26826 under 42 CFR Part 482, Requirements for Long Term Care Facilities. Deficiencies were cited for complaint investigation #26262.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, facility policy review, observation, and interview, the facility failed to implement the abuse policy after an allegation of abuse for one resident (#11) of twenty-six residents reviewed. The findings included: Resident #11 was admitted to the facility on September 10, 2009, with diagnoses including Status Post Vehicle Collision with Sternal Fracture, Right Rib Fracture, Cerebrovascular Accident, Left Hemiparesis, Hypertension, Hypothyroidism, and Sleep Apnea. Medical record review of the Minimum Data Set dated August 22, 2010, revealed the resident had short and long term memory deficits and severely	F 226	1) Facility made a self-report on 7/07/10, for Resident #11. 12-26-10 2) Residents in the facility have the potential to be affected. 12-26-10 3) Staff received in-services on 12/07/10 regarding immediate intervention and reporting to supervisors according to facility policy and procedures. 12-26-10 4) DON and/or designee will Report non-compliance to the PI Committee (Medical Director, DON, Administrator, RSM, ADON, SSD, Pharmacist, FSS, ACT Director, ES Director HR Director) monthly to review, analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved. 12-26-10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla K Saunders	Administrator	1-07-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 impaired cognitive skills. Review of a facility investigation revealed Registered Nurse (RN) #3 had heard Resident #11 yelling on July 3, 2010, at sometime between 4:00 and 5:00 a.m., (exact time unknown). Continued review of the facility investigation revealed RN #3 entered resident #11's room and observed Certified Nursing Assistant (CNA) #1 and CNA #2 providing incontinence care to the resident. Continued review of the facility investigation revealed RN #3 had observed CNA #1 "hit across resident's mouth." Review of facility policy Managing Incidents of Alleged Abuse & Neglect revealed "...Provide protection...Separate the alleged perpetrator from the resident(s). If the perpetrator is a staff member, send the employee home pending investigation..." Observation on December 6, 2010, at 11:55 a.m., revealed the resident seated in a wheelchair at the side of the bed. Telephone interview on December 7, 2010, at 11:00 a.m., with RN #3 revealed RN #3 heard the resident yelling and entered the resident's room to investigate on July 3, 2010 at approximately 5:00 a.m. Continued interview revealed RN #3 observed CNA #1 and CNA #2 providing incontinence care to resident #11. Continued interview revealed RN #3 then observed CNA #1 slap the resident's mouth with a disposable incontinence wipe and state to the resident to hush. Continued interview revealed RN #3 did not intervene or confront CNA #1 but returned to the nursing station and called the unit manager and the Director of Nursing by phone to report the	F 226		

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F 226	Continued From page 2 allegation. Continued interview revealed RN #3 had observed CNA #1 and CNA #2 exit the resident's room and at a later time RN #3 returned to the resident's room and checked the resident for injury. Continued interview revealed the resident was sleeping and no injuries were noted to the resident. Interview with RN #3 confirmed RN #3 failed to send CNA #1 home pending investigation of the allegation. Interview on December 6, 2010, at 3:50 p.m., with the Director of Nursing (DON), in the conference room, revealed CNA #1 was suspended (by telephone, after completing working the 10:00 p.m., to 5:00 a.m., shift) on July 3, 2010, by the DON pending investigation of the allegation. Continued interview with the DON confirmed CNA #1 continued to work and complete the shift after the allegation and confirmed CNA #1 was not immediately sent home after the allegation was made.	F 226		
F 281 SS=D	C/O #26262 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to obtain a physician's order for the administration of oxygen for one resident (#1) of twenty-six residents reviewed. The findings included:	F 281		

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F 281	Continued From page 3 Resident #1 was admitted to the facility on July 16, 2010, with diagnoses including Muscle Weakness, Hypopotassemia, Diabetes Mellitus II, Right Bundle Branch Block, Hypertension, Abnormal Involuntary Movements, Esophageal Reflux, and Iron Deficiency Anemia. Medical record review of hospital physician orders dated November 17, 2010, revealed no orders for oxygen administration. Medcial record review of the physician's orders for December 2010 revealed no physician's order for oxygen administration. Observation on December 6, 2010, at 9:45 a.m., revealed the resident in bed with oxygen in use at 2.5 liters per minute (l/m). Observation on December 7, 2010, at 9:55 a.m, revealed the resident receiving oxygen at 3 (l/m). Interview with the Medical Director on December 8, 2010, at 6:30 p.m., in the Director of Nursing's office, confirmed the hospital orders did not reflect the use of the oxygen and confirmed no physician orders were given for the use of the oxygen since the resident's return to the nursing home on November 17, 2010.	F 281	1) Physician was notified regarding Resident #1 on 12/08/10. 2) Residents receiving oxygen have the potential to be affected. 3) Nursing staff will audit residents receiving oxygen to insure that physician orders are in place weekly X 4 weeks then monthly X 2. Nurses received in-service on obtaining physician orders for residents receiving oxygen. 4) DON and/or designee will report Findings to PI Committee (Medical Director, Administrator, DON, ADON, Pharmacist, FSS, SSD, ACT Director, RSM, HR Director, Plant Director, ES Director, HIM, Admissions Director) monthly to review, analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved.	12-26-10 12-26-10 12-26-10 12-26-10
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, observation, and interview, the facility failed to ensure safety devices were in place for one resident (#3) of twenty-six residents reviewed. The findings included: Resident #3 was admitted to the facility on December 7, 2009 with diagnosis including Osteoporosis, Muscle Weakness, Chronic Blood Loss Anemia, History of Fall, and Difficulty Walking. Medical record review of the Minimum Data Set dated September 19, 2010, revealed the resident had no memory deficits, had difficulty making decisions in new situations, required extensive assistance with transfers, required limited assistance in locomotion on and off the unit, and had experienced a fall in the past 31-180 days. Medical record review of Fall Risk Assessments since December 17, 2009, revealed the resident was high risk for falls. Review of a facility investigation dated April 23, 2010, revealed the resident had slid out of the wheelchair and dycem had been applied to the wheelchair. Medical record review of the current care plan revealed a talking PSA (Pressure Sensitive Alarm) had been added to the resident's wheelchair and bed and dycem had been placed in the seat of the wheelchair.	F 323	1) On 12/07/10, Resident #3 Received safety alarm for bed and wheelchair and dycem was placed in wheelchair. 12-26-10 2) Resident's with physician orders for safety devices and alarms have the potential to be affected. 12-26-10 3) Audits will be conducted by unit Managers to insure appropriate Alarms and safety devices are in Place according to physician orders Weekly X 4 weeks then monthly X 2. 12-26-10 4) DON and/or designee will report Findings to PI Committee (Medical Director, DON, Administrator, ADON, Pharmacist, FSS, RSM, SSD, ACT Director, ES Director, Plant Director, Medical Records, HR Director) monthly to review, analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved. 12-26-10	

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F 323	Continued From page 5 Observation on December 6, 2010, at 12:40 p.m., revealed the resident in a wheelchair without the personal safety alarm or the dycem in place. Observation on December 6, 2010, at 1:55 p.m., revealed the resident in bed without a personal safety alarm in place. Observation on December 7, 2010, at 9:05 a.m., with the Director of Nursing revealed the resident in bed without the personal safety alarm in place and no dycem or personal safety alarm on the wheelchair. Interview with the Director of Nursing on December 7, 2010 at 9:05 a.m., in the resident's room, confirmed the facility had failed to ensure the safety devices were in place to alert staff of unassisted transfers and sliding down in the wheelchair.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of manufacturer's specifications, and interview, the facility failed to prevent medication errors less than five percent resulting in three errors within forty-two opportunities to equal an error rate of seven percent. The findings included: Medication Error #1:	F 332		

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F 332	Continued From page 6 Observation on December 6, 2010, at 3:40 p.m., at the North West Split Cart revealed RN #1 administered one Metformin (medication for Diabetes) 1000 mg (milligram) tablet to Resident #23. Medical record review of the signed physician order dated December 1, 2010, for Resident #23 revealed an order for "...METFORMIN HCL (Hydrochloride) 1000MG (milligram) TABLET...TAKE 1 TAB (tablet) BY MOUTH WITH BREAKFAST" followed by handwritten instructions "...and supper..." Interview with RN #1 on December 6, 2010, at 4:30 p.m., at the North West Split Cart outside the room of Resident #23 confirmed one medication error occurred when the Metformin 1000 mg tablet was administered 80 minutes before supper and not with supper per the physician's order. Further interview revealed supper would be served at 5 p.m., on the North Wing. Interview with the Food Service Director on December 7, 2010, at 4:05 p.m., in the Dietary Service Office confirmed North Wing supper trays were served between 5:30 p.m., and 5:35 p.m. on December 6, 2010. Medication Error #2 Observation on December 6, 2010, at 3:40 p.m., at the North West Split Cart revealed RN #1 administered two puffs of Advair (oral inhaler for asthma) by mouth ad exited the resident's room. The Advair inhaler contained two medications (Fluticasone (corticosteroid medication) 115 mcg (microgram) and Salmeterol (medication for the	F 332	1) MD was notified of medication errors on 12/08/10. 2) Residents receiving medications have the potential to be affected. 3) Nurses will receive in-service on 12-22-10 regarding appropriate medication administration per consultant pharmacist. Medication administration audits Will be conducted weekly X 4 weeks Then monthly X 2. 4) DON and/or designee will report findings to PI Committee (Medical Director, Administrator, DON, Pharmacist, FSS, RSM, SSD, HR, ES Director, ACT Director, Plant Director, HIM), monthly to review, analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved.	12-26-10 12-26-10 12-26-10 12-26-10

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F 332	Continued From page 7 prevention of bronchospasm) 21 mcg) per puff. Medical record review of a physician's order dated December 1, 2010, for Resident #23 revealed "...ADVAIR..115-21MCG (microgram) AER (aerosol)...INHALATIONS TAKE 2 PUFFS TWICE DAILY..." Review of the manufacturer's specifications in the package insert for Advair oral inhaler revealed "...Instructions for taking a dose from your ADVAIR...After you finish taking this medicine, rinse your mouth with water. Spit out the water. Do not swallow it...Common side effects...include...upper respiratory tract infection...throat irritation..." Review of facility policy How to Use a Metered Dose Inhaler revealed "...Have the resident rinse out his or her mouth and spit out the rinse water..." Interview with RN #1 on December 6, 2010, at 4:30 p.m., at the North West Split Cart outside the room of Resident #23 confirmed one medication error occurred when the resident did not rinse mouth and spit out the rinse water after the administration of the Advair Oral Inhaler. Medication Error #3 Observation on December 7, 2010, at 7:30 a.m., at the North Wing Cart #1 revealed LPN #1 administered one dose of Furosemide (diuretic) 20 mg tablet to Resident #24. Medical record review of a physician's order dated December 1, 2010, for Resident #24	F 332		

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F 332	Continued From page 8 revealed an order for "...FUROSEMIDE...10MG/1ML (milliliter)SOLUTION...GIVE 3ML (30MG) BY MOUTH EVERY DAY..." Interview with LPN #1 on December 7, 2010, at 10:40 a.m. at the North Wing Nursing Station confirmed one medication error occurred when the wrong dose of Furosemide 20 mg tablet was administered instead of the Furosemide 30 mg dose ordered by the physician.	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility dietary department failed to maintain the mixer in a sanitary manner and failed to store dietary equipment and food in a sanitary manner. The findings included: Observation on December 6, 2010, at 10:23 a.m., with the Dietary Manager, of the dish machine in operation revealed fourteen dish racks in contact with the floor in front of the dish machine. Further observation revealed a measuring cup and the	F 371		

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F 371	Continued From page 9 cup handle in contact with the rice stored in a bin. Continued observation revealed a mixer covered in plastic. Continued observation revealed the mixer under side area of the beater arm and the mixer bowl guard had multiple brown and white dried splatters and a white powdery substance present. Interview, with the Dietary Manager, on December 6, 2010 at 10:23 a.m., confirmed the following: 1.) There were fourteen dish racks in contact with the floor in front of the dish machine in operation. 2.) There was a measuring cup and the cup handle in contact with the rice stored in a bin. 3.) The mixer under side area of the beater arm and the mixer bowl guard had multiple brown and white dried splatters and a white powdery substance present. Continued interview revealed the plastic cover over the mixer meant the mixer was clean and ready for use. Further interview confirmed the above items were not maintained in a sanitary manner.	F 371	1) Dish racks were removed from the floor on 12/06/10. Measuring cup in rice bin was removed on 12/06/10. The mixer was immediately cleaned on 12/06/10.	12-26-10
			2) Dietary Manager conducted an in-service with dietary staff regarding sanitation on 12/09/10.	12-26-10
			3) Dish racks, measuring cups and mixer will be added to dietary cleaning schedules. Audits will be conducted Weekly X 4 weeks then monthly X 2 by FSD and/or designee To insure compliance.	12-26-10
			4) FSS and/or designee will report findings to the PI Committee (Medical Director, DON, ADON, Pharmacist, HR Director, FSS, ES Director, ACT Director, Administrator, Marketing Director, SSD), monthly to review and analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved.	12-26-10
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review individual monthly medication regimen reviews, facility pharmacy policy, and interview, the facility failed to act upon 27 of 29 drug regimen reviews completed by the Consultant Pharmacist for the months of September 2010 and October 2010. The findings included: Record review of the individual (resident) monthly medication regimen reviews completed by the Consultant Pharmacist dated Sepetember 15, 2010, and September 17, 2010, in the Conference Room with the Director of Nursing (DON) revealed 19 of 20 recommendations for the month of September 2010 had not been acted upon. Further record review of the individual monthly medication regimen reviews dated October 20, 2010, revealed 8 of 9 recommendations by the Consultant Pharmacist for the month of October 2010 had not been acted upon. Review of facility pharmacy policy Medication Regimen Review revealed "...PROCEDURE...6. Facility should ensure that Facility Physicians/Prescribers are provided with copies of the MRRs (Medication Regimen Reviews). 7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the	F 428	1) September and October 2010 Medication Regimen Reviews with recommendations were reviewed by Nurse Practitioner and/or MD for any new physician orders. 2) Residents with Medication Regimen Reviews have the potential to be affected. 3) HIM received education on 12/09/10 on process to insure MRR recommendation are reviewed timely with MD and/or NP. DON will audit MRR recommendations within 14 days To insure compliance. 4) HIM will report findings to PI Committee (Medical Director, DON, ADON, Administrator, Pharmacist, ACT Director, SSD, FSS, ES Director, RSM, HR Director) monthly to review, analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved.	12-26-10 12-26-10 12-26-10 12-26-10

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LIFE CARE CENTER OF COLLEGEDALE	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

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F 428	Continued From page 11 recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 8. Facility should provide the Medical Director with a copy of the MRRs and should alert the Medical Director where MRRs require follow-up. 9. Facility should maintain copies of MRRs on file in Facility, either as part of the resident's permanent medical record or in a special file..." Interview with the DON on December 8, 2010, at 2:20 p.m., in the Conference Room confirmed the facility failed to ensure 27 of 29 individual monthly drug regimen reviews completed by the Consultant Pharmacist for the months of September 2010 and October 2010 were acted upon by the attending physician and the DON.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		

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F 431	Continued From page 12 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy, and interview, the facility failed to ensure an account of all controlled drugs were maintained and periodically reconciled for two (North Wing Cart #1 and North Wing Cart #2) of six medication carts and one (Resident #6) of 26 twenty-six residents reviewed; and drugs were stored under proper temperature controls for two of three medication refrigerators. The findings included: North Wing Cart #1	F 431	1) Medication carts were audited on 12/06/10 to insure accurate narcotic reconciliation processes. Two (2) refrigerators were replaced to insure appropriate storage of medications and medications were replaced on 12/06/10.	12-26-10
			2) Resident's receiving narcotic medications have the potential to be affected. Resident's who have medications requiring refrigeration have the potential to be affected.	12-26-10
			3) Audits of narcotic reconciliation Sheets will be conducted by Unit managers weekly X 4 weeks Then monthly X 2. Nurses will receive In-service by 12/23/10 to ensure Accuracy of the narcotic reconciliation. Weekly audits of medication refrigerators Will be conducted by unit managers To insure proper storage of medication. Nurses will receive in-service by 12/23/10 Regarding notification of any issues With storage of medications.	12-26-10
			4) DON and/or designee will report findings to PI Committee (Medical Director, Administrator, RSM, SSD, ADON, Pharmacist, FSS, HR Director, ES Director, ACT Director) Monthly to review, analyze and make Recommendations as needed for three (3) consecutive months and/or until compliance is achieved.	12-26-10

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F 431	Continued From page 13 Observation and review of the Individual Patient Narcotic Records with the Director of Nursing (DON) on December 6, 2010, at 11:10 a.m., during the North Wing Cart #1 controlled substance record audit revealed 43 Individual Patient's Controlled Substances Records in the North Wing narcotic notebook and 43 corresponding narcotic medications in the North Wing Cart #1 narcotic box. Further observation of the North Wing Cart #1 December 2010 Narcotic Count Verification Sheet revealed only 42 Individual Patient's Controlled Substances Records were reconciled with 42 corresponding narcotic medications on December 6, 2010, at 6 a.m., by LPN #4 (the incoming nurse on the 6 a.m., to 2 p.m., shift) with RN #2 (the offgoing nurse for the 10 p.m., to 6 a.m., shift). Record review of the North Wing Cart #1 Narcotic Count Verification sheet revealed "...Schedule drugs are to be counted at the beginning and the conclusion of each shift. The incoming nurse and the offgoing (nurse) must count both the number of drugs on each card, and the total number of cards and narcotic sheets...Any discrepancies are to be reported to the DON immediately. Neither associate can leave until count is corrected..." Interview with the DON on December 6, 2010, at 11:15 a.m., at the North Wing Cart #1 confirmed the Narcotic Count Verification Sheet reconciliation by LPN #4 (the incoming nurse on the 6 a.m., to 2 p.m., shift) with RN #2 (the offgoing nurse for the 10 p.m., to 6 a.m., shift) was incorrect on December 6, 2010, at 6:00 a.m., and the discrepancy had not been reported to the DON.	F 431		

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F 431	Continued From page 14 North Wing Cart #2 Observation and review of the Inidividual Patient's Narcotic Record with the DON on December 6, 2010, at 11:20 a.m., during the North Wing Cart #2 controlled substance record audit revealed 57 Individual Patient's Controlled Substances Records in the North Wing narcotic notebook were reconciled with 57 corresponding narcotic medications on December 6, 2010, at 6 a.m., by LPN #3 (the incoming nurse on the 6 a.m., to 2 p.m., shift) with LPN #2 (the offgoing nurse for the 10 p.m., to 6 a.m., shift). Further observation revealed one Individual Patient's Narcotic Record documenting 13 Ativan (medication for agitation) 2 mg (milligram) per ml (milliliter) injections available for Resident #6. Further observation revealed the corresponding physical narcotic count in the North Wing Cart #2 narcotic box was 12 Ativan 2 mg per ml injections for Resident #6. Further review of the Individual Patient's Narcotic Record revealed the beginning count of 20 Ativan 2 mg per ml vials (unknown date of receipt) had been changed to 19 Ativan 2 mg per ml vials prior to the first documentation of use on July 19, 2010, without an explanation for removing the vial. Interview with the DON on December 6, 2010, at 11:25 a.m., at the North Wing Cart #2 confirmed two entries for Ativan 2 mg per ml injections were missing from the Individual Patient's Narcotic Record for Resident #6 and the Narcotic Count	F 431		

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F 431	Continued From page 15 Verification Sheet reconciliation by LPN #3 (the incoming nurse on the 6 a.m., to 2 p.m., shift) with LPN #2 (the offgoing nurse for the 10 p.m., to 6 a.m., shift) was incorrect on December 6, 2010, at 6:00 a.m., and the discrepancy had not been reported to the DON. Observation of the temperature in the North Wing medication refrigerator on December 6, 2010, at 10:55 a.m., with the DON revealed a reading of twenty-eight degrees Fahrenheit. Further observation of the contents of the refrigerator revealed one unopened 2.5 ml bottle of Xalatan (eye medication for Glaucoma) 0.005% and the following unopened vials of insulin (injection medication for Diabetes): seven 10 ml vials of Novolog N 100 units per ml; and three vials of Novolin N 100 units per ml. Review of Facility Policy Drug Room Inspection Report revealed the medication refrigerator was to be maintained between 36 to 46 degrees Fahrenheit. Interview with the DON on December 6, 2010, at 11:00 a.m, in the North Wing medication room confirmed the refrigerator temperature was too low for the proper storage of medications. Observation of the temperature in the South Wing medication refrigerator on December 6, 2010, at 2:00 p.m., with the DON revealed a reading of	F 431		

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F 431	Continued From page 16 thirty degrees Fahrenheit. Further observation of the contents of the refrigerator revealed one unopened vial of Lantus (medication injection for Diabetes) Insulin 100 units per ml. Interview with the DON on December 6, 2010, at 2:10 p.m., in the South Wing medication room confirmed the refrigerator temperature was too low for the proper storage of medications.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

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F 441	Continued From page 17 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store nebulizer tubing and mask, and a tracheostomy humidifier mask in a sanitary condition for one resident (#3) of twenty-six residents records reviewed. The findings included: Observation on December 6, 2010 at 12:27 p.m., revealed a nebulizer on one bed side table and a tracheostomy humidifier machine on a bed side table, on the opposite side of the bed, of resident #3. Further observation revealed the nebulizer tubing and mask were in contact with the bed side table and the uncovered nebulizer. Continued observation revealed the tracheostomy humidifier mask was in contact with the bed side table. Interview, with Certified Nurse Aide #4 and Licensed Practical Nurse #3, on December 6, 2010, at 12:32 p.m., in the resident's room, confirmed the nebulizer tubing and mask were in contact with the uncovered nebulizer and the bed side table. Continued interview confirmed the tracheostomy humidifier mask was in contact with the bed side table. Continued interview confirmed	F 441	1) Nebulizer, mask and tracheostomy mask for Resident #3 was placed in plastic bags on 12/06/10. 2) Resident's with physician orders for nebulizer treatment, trach and/or oxygen have the potential to be affected. 3) Audits conducted by unit managers Of residents with nebulizer treatments, Trach and/or oxygen to insure proper Storage in a plastic bag after use Weekly X 4 weeks then monthly X 2. Nursing staff will receive in-service By 12/23/10 to insure proper storage. 4) DON and/or designee will report findings to PI Committee (Medical Director, ADON, Administrator, Pharmacist, ES Director, RSM, SSD, FSS, ACT Director, HR Director) monthly to review, analyze and make recommendations as needed for three (3) consecutive months and/or until compliance is achieved.	12-26-10 12-26-10 12-26-10 12-26-10

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F 441	Continued From page 18 the the nebulizer tubing and mask, and the tracheotomy humidifier mask were to be stored in a plastic bag after use. Interview with Registered Nurse (RN) #6, on December 6, 2010 at 12:35 p.m., in the resident's room, confirmed the nebulizer tubing and mask, and the tracheotomy humidifier mask were not stored properly after use.	F 441		